APPENDIX A

Final Rules

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 C.F.R. Part 54 as follows:

PART 54 - UNIVERSAL SERVICE

1. The authority citation for Part 54 continues to read as follows:

Authority: 47 U.S.C. §§ 1, 4(i), 201, 205, 214, and 254 unless otherwise noted.

2. Amend § 54.601 by removing paragraphs (a)(3), (b)(3), and (b)(4), redesignating paragraphs (a)(4) and (a)(5) as (a)(3) and (a)(4), revising paragraphs (a)(1), newly redesignated (a)(3), and (c), and adding paragraph (d) to read as follows:

§ 54.601 Eligibility.

(a) * * *

(1) Except with regard to those services provided under § 54.621(b), only an entity that is either a public or non-profit rural health care provider, as defined in this section, shall be eligible to receive supported services under this subpart.

* * * * *

(3) For purposes of this subpart, a rural health care provider is a public or non-profit health care provider located in a rural area, as defined in this subpart.

* * * * *

(c) Services.

(1) Any telecommunications service that is the subject of a properly completed bona fide request by a rural health care provider shall be eligible for universal service support, subject to the limitations described in this paragraph. The length of a supported telecommunications service

may not exceed the distance between the health care provider and the point farthest from that provider on the jurisdictional boundary of the largest city in a state as defined in § 54.625(a).

(2) Internet Access and Limited Toll-Free Access to Internet.

(i) For purposes of this subpart, eligible Internet access is an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web.

(ii) Internet access shall be eligible for universal service support under § 54.621(a).

(iii) Limited toll-free access to an Internet service provider shall be eligible for universal service support under § 54.621(b).

(d) Allocation of Discounts. An eligible health care provider that engages in eligible and ineligible activities or that collocates with an entity that provides ineligible services shall allocate eligible and ineligible activities in order to receive a prorated discount for eligible activities. Health care providers shall choose a method of cost allocation that is based on objective criteria and reasonably reflects the eligible usage of the facilities.

§ 54.603 [Amended]

3. Amend § 54.603 by replacing the term "Rural Health Care Corporation" in paragraphs (b)(1), (b)(2), (b)(3), (b)(4), and (b)(5) with "Rural Health Care Division."

4. Amend § 54.605 by removing paragraph (c), redesignating paragraphs (d) and (e) as (c) and (d), and revising paragraphs (a) and (b) to read as follows:

§ 54.605 Determining the urban rate.

(a) If a rural health care provider requests an eligible service to be provided over a distance that is less than or equal to the "standard urban distance," as defined in paragraph (c) of this section, for the state in which it is located, the urban rate for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally

similar service in any city with a population of 50,000 or more in that state, calculated as if it were provided between two points within the city.

(b) If a rural health care provider requests an eligible service to be provided over a distance that is greater than the "standard urban distance," as defined in paragraph (c) of this section, for the state in which it is located, the urban rate for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service provided over the standard urban distance in any city with a population of 50,000 or more in that state, calculated as if the service were provided between two points within the city.

* * * * *

5. Revise § 54.609 to read as follows:

§ 54.609 Calculating support.

(a) Except with regard to services provided under § 54.621 and subject to the limitations set forth in this subpart, the amount of universal service support for an eligible service provided to a public or non-profit rural health care provider shall be the difference, if any, between the urban rate and the rural rate charged for the service, as defined herein. In addition, all reasonable charges that are incurred by taking such services, such as state and federal taxes shall be eligible for universal service support. Charges for termination liability, penalty surcharges, and other charges not included in the cost of taking such service shall not be covered by the universal service support mechanisms. Rural health care providers may choose one of the following two support options.

(1) Distance-Based Support. The Administrator shall consider the base rates for telecommunications services in rural areas to be reasonably comparable to the base rates charged for functionally similar telecommunications service in urban areas in that state, and, therefore,

the Administrator shall not include these charges in calculating the support. The Administrator shall include, in the support calculation, all other charges specified, and all actual distance-based charges as follows:

(i) If the requested service distance is less than or equal to the SUD for the state, the distance-based charges for the rural health care provider are reasonably comparable to those in urban areas, so the health care provider will not receive distance-based support.

(ii) If the requested service distance is greater than the SUD for the state, but less than the maximum allowable distance, the distance-based charge actually incurred for that service can be no higher than the distance-based charges for a functionally similar service in any city in that state with a population of 50,000 or more over the SUD.

(iii) "Distance-based charges" are charges based on a unit of distance, such as mileage-based charges.

(iv) Except with regard to services provided under § 54.621, a telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the actual distance-based charges for the health care provider's portion of the shared telecommunications services.

(2) Base Rate Support. If a telecommunications carrier, health care provider, and/or consortium of health care providers reasonably determines that the base rates for telecommunications services in rural areas are not reasonably comparable to the base rates charged for functionally similar telecommunications service in urban areas in that state, the telecommunications carrier, health care provider, and/or consortium of health care providers may request that the Administrator perform a more comprehensive support calculation. The requester shall provide to the Administrator the information to establish both the urban and rural rates consistent with § 54.605 and § 54.607, and submit to the Administrator with Form 466 all of the documentation

necessary to substantiate the request.

(i) Except with regard to services provided under § 54.621, a telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the applicable rural base rates for telecommunications service for the health care provider's portion of the shared telecommunications services, as well as the applicable urban base rates for the telecommunications service.

(b) Absent documentation justifying the amount of universal service support requested for health care providers participating in a consortium, the Administrator shall not allow telecommunications carriers to offset, or receive reimbursement for, the amount eligible for universal service support.

(c) The universal service support mechanisms shall provide support for intrastate telecommunications services, as set forth in § 54.101(a), provided to rural health care providers as well as interstate telecommunications services.

(3) Satellite services.

(i) Rural public and non-profit health care providers may receive support for rural satellite services, even when another functionally similar terrestrial-based service is available in that rural area. Discounts for satellite services shall be capped at the amount the rural health care provider would have received if they purchased a functionally similar terrestrial-based alternative.

(ii) Rural health care providers seeking discounts for satellite services shall provide to the Administrator with the Form 466 documentation of the urban and rural rates for the terrestrial-based alternatives.

(iii) Where a rural health care provider seeks a more expensive satellite-based service when a less expensive terrestrial-based alternative is available, the rural health care provider shall be

responsible for the additional cost.

6. Amend § 54.613 by revising paragraph (a) to read as follows:

§ 54.613 Limitations on supported services for rural health care providers.

(a) Upon submitting a bona fide request to a telecommunications carrier, each eligible rural health care provider is entitled to receive the most cost-effective, commercially-available telecommunications service at a rate no higher than the highest urban rate, as defined in § 54.605, at a distance not to exceed the distance between the eligible health care provider's site and the farthest point on the jurisdictional boundary of the city in that state with the largest population.

* * * * *

7. Revise § 54.619 to read as follows:

§ 54.619 Audits and recordkeeping.

(a) Health care providers.

(1) Recordkeeping. Health care providers shall maintain for their purchases of services supported under this subpart documentation for five years from the end of the funding year sufficient to establish compliance with all rules in this subpart. Documentation must include, among other things, records of allocations for consortia and entities that engage in eligible and ineligible activities, if applicable.

(2) Production of records. Health care providers shall produce such records at the request of any auditor appointed by the Administrator or any other state or federal agency with jurisdiction.

(3) Random audits. Health care providers shall be subject to random compliance audits to ensure that requesters are complying with the certification requirements set forth in § 54.615(c) and are otherwise eligible to receive universal service support and that rates charged comply with the statute and regulations.

(4) Annual report. The Administrator shall use the information obtained under paragraphs (a)(1), (a)(2), (b)(1) and (b)(2) of this section to evaluate the effects of the regulations adopted in this subpart and shall report its findings to the Commission on the first business day in May of each year.

8. Revise § 54.621 to read as follows:

§ 54.621 Access to advanced telecommunications and information services.

(a) Twenty-five percent of the monthly cost of eligible Internet access shall be eligible for universal support. Health care providers shall certify that the Internet access selected is the most cost-effective method for their health care needs as defined in § 54.615(c)(7), and that purchase of the Internet access is reasonably related to the health care needs of the rural health care provider.

(b) Each eligible health care provider that cannot obtain toll-free access to an Internet service provider shall be entitled to receive the lesser of the toll charges incurred for 30 hours of access per month to an Internet service provider or $180 per month in toll charge credits for toll charges imposed for connecting to an Internet service provider.

9. Amend § 54.625 by revising paragraph (a) to read as follows:

§ 54.625 Support for services beyond the maximum supported distance for rural health care providers.

(a) The maximum support distance is the distance from the health care provider to the farthest point on the jurisdictional boundary of the city in that state with the largest population, as calculated by the Administrator.

* * * * *

APPENDIX B

List of Parties Filing Comments in Response to the Notice of Proposed Rulemaking

Comments

1. Adams County Health Department (Adams Co. Health Dept.)
2. Alaska, State of (Alaska)
3. Alaska Federal Health Care Access Network (AFHCAN)
4. Alaska Telehealth Advisory Council (Alaska Telehealth)
5. Alliance Information Management, Inc. (Alliance)
6. American Hospital Association (AHA)
7. American Samoa Medical Center Authority, LBJ Tropical Medical Center (American Samoa Medical Center)
8. American Samoa Telecommunications Authority (ASTCA)
9. American Telemedicine Association (ATA)
10. Arizona Telemedicine Program (Arizona Telemedicine)
11. Arkansas Department of Information Systems (Arkansas DIS)
12. Avera Health (Avera)
13. Beacon Telecommunications Advisors, LLC (Beacon)
14. California Primary Care Association (CA Primary Care Assoc.)
15. California Rural Health Policy Council (CA Rural Health Policy)
16. California Telehealth & Telemedicine Center (CTTC)
17. Canter for Rural Health, Illinois Department of Public Health (Illinois Center for Rural Health)
18. Center for Telemedicine Law (CTL)
19. Coder, Denise (Coder)
20. Children's Hospital of L.A. (L.A. Children's Hospital)
21. Clifford, Larry (Clifford)
22. Cortland County Health Department (Cortland Co. Health Dept.)
23. The Evangelical Lutheran Good Samaritan Society (Evangelical Lutheran)
24. Federal Regional Council (FRC)
25. Florida Public Service Commission (Florida PSC)
26. General Communications, Inc. (GCI)
27. Grogg, Kevin, Shepherd Center (Grogg)
28. Guam Department of Mental Health and Substance Abuse (Guam Dept. of MHSA)
29. Guam Department of Public Health and Social Services (Guam Dept. of PHSS)
30. Guam Memorial Hospital Authority (Guam Memorial Hosp.)
31. Healthcare Anywhere, Inc. (Healthcare)
32. Institute of Rural Health, The (Institute of Rural Health)
33. Intelenet Commission (Intelnet)
34. IT&E Overseas, Inc. (IT&E)
35. Kansas Department of Health & Environment (Kansas DHE)
36. Kansas Hospital Association (Kansas Hosp. Assoc.)

37. Kingston eHealth (Kingston eHealth)
38. Lane Co. Health Department (Lane Co. Health Dept.)
39. Madden, Karen A. (Madden)
40. Marquette General Health System (MGHS)
41. Mayo Foundation (Mayo)
42. Mid-Nebraska Telemedicine Network, Good Samaritan Health Systems and, Kearney Nebraska (Mid-Nebraska Telemedicine)
43. Midwest Networks, LLC (Midwest Networks)
44. Minnesota Ambulance Association (Minn. Ambulance Assoc.)
45. Minnesota Rural Health Association (Minn. Rural Health Assoc.)
46. Mobile Satellite Ventures Subsidiary LLC (MSV)
47. Montana Healthcare Telecommunications Alliance (MHTA)
48. National Association of County and City Health Officials (NACCHO)
49. National Organization of State offices of Rural Health (NOSORH)
50. National Rural Health Association (NRHA)
51. National Telecommunications Cooperative Association (NTCA)
52. Nebraska Office of Rural Health (Nebraska Office of Rural Health)
53. Nevada State Office of Rural (Nevada State Office)
54. New Mexico Health Resources, Inc. (NM Health Resources)
55. Northern Sierra Rural Health Network (NSRHN)
56. Northwest TeleHealth (Northwest TeleHealth)
57. Pan Pacific Education and Communication (Pan Pacific Education and Communication)
58. Experiment by Satellite (PEACESAT)
59. PCI Communications (PCI)
60. Poudre Valley Health System (Poudre Valley Health)
61. Rural Wisconsin Health Cooperative (RWHC)
62. Startec Global Communications Corporation (Startec)
63. Tri-County Memorial Hospital (Tri-County Memorial Hosp.)
64. University of Arizona Health Sciences Center (Univ. of Arizona Health Sciences)
65. University of New Mexico Health and Sciences Center (Univ. of NM Health and Sciences)
66. University of Tennessee Health Science Center (Univ. of Tennessee Health Science)
67. University of Vermont College of Medicine (Univ. of Vermont College of Medicine)
68. University of Virginia Office of Telemedicine Health Systems (UVA)
69. VA Medical and Regional Office Center Honolulu (VAMROC-Honolulu)
70. Verizon (Verizon)
71. Washington Rural Health Association (Washington Rural)
72. Western Governors' Association (WGA)
73. Williams, Rustan (Williams)
74. WorldCom, Inc. (WorldCom)
75. Yurok Tribe (Yurok Tribe)

Reply Comments

1. Arkansas Department of Information Systems (Arkansas DIS)
2. Blue Cross of California (Blue Cross)
3. Center for Telemedicine Law (Center for Telemedicine)

4. Commonwealth of the Northern Mariana Islands, Office of the Governor (Commonwealth of the Northern Mariana Islands)
5. Federal Regional Council (FRC)
6. General Communication, Inc. (General Communication)
7. Healthcare Anywhere, Inc. (Healthcare Anywhere)
8. Hemophilia Treatment Center (HTC)
9. Mobile Satellite Ventures Subsidiary LLC (MSV)
10. Pacific Islands Health Officers Association (Pacific Islands HOA)
11. Pennsylvania Public Utility (PA Public Utility)
12. Qwest Communications International Inc. (Qwest)
13. SBC Communications Inc. and BellSouth Corp. (SBC/BellSouth)
14. Verizon (Verizon)

Ex Partes

1. Rep. Boucher (Boucher)
2. Guam, Officer of the Governor (Guam)
3. Healthcare Anywhere (Healthcare Anywhere)
4. National Telecommunications Cooperative Association (NTCA)
5. University of Virginia Office of Telemedicine Health Systems (UVA)
6. Washington Federal Strategies (Washington Federal)

APPENDIX C

FINAL REGULATORY FLEXIBILITY ANALYSIS

(*REPORT AND ORDER*)

1. As required by the Regulatory Flexibility Act of 1980, as amended (RFA),[1] an Initial Regulatory Flexibility Analysis (IRFA) was incorporated in the Notice of Proposed Rulemaking.[2] The Commission sought written public comments on the proposals in the NPRM, including comment on the IRFA. The Commission received seventy-five comments, fourteen reply comments, and six *ex partes* in response to the *NPRM*. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.[3]

A. Need for, and Objectives of, the Report and Order

2. The Commission is required by section 254 of the Act to promulgate rules to implement the universal service provisions of section 254.[4] On May 8, 1997, the Commission adopted rules that reformed its system of universal service support mechanisms so that universal service is preserved and advanced as markets move toward competition.[5] Among other things, the Commission adopted a mechanism to provide discounted telecommunications services to public or non-profit health care providers that serve persons in rural areas. Over the last few years, important changes in the rural health community prompt us to review the rural health care universal service support mechanism.[6] In this *Report and Order*, we adopt several modifications to the Commission's rules to improve the effectiveness of the rural health care universal service support mechanism and increase utilization of this mechanism by rural health care providers.

3. Specifically, in the *Report and Order*, we clarify the scope of entities eligible to receive discounts.[7] We conclude that dedicated emergency departments of rural for-profit hospitals that participate in Medicare should be deemed "public" health care providers eligible to receive prorated rural heath care support.[8] We believe this clarification is necessary to give

---

[1] *See* 5 U.S.C. § 603. The RFA, *see* 5 U.S.C. §§ 601–12, has been amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Pub. L. No. 104-121, Title II, 110 Stat. 857 (1996).

[2] *Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking, WC Docket No. 02-60, 17 FCC Rcd 7806 (2002) (*NPRM*).

[3] *See* 5 U.S.C. § 604.

[4] 47 U.S.C. § 254.

[5] *1997 Universal Service Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

[6] *See supra* paras. 8-10.

[7] *See supra* paras. 13-17.

[8] *See supra* para. 13.

meaning to the term "public" health care provider under the rural health care program. Moreover, we also determine that dedicated emergency departments in for-profit rural hospitals constitute "rural health clinics."[9] These entities are generally the initial point of entry into the healthcare system for any person suffering the consequences of a severe catastrophe or accident and constitute a vital segment of the health care community, particularly in the event of a national public health emergency. Additionally, we conclude that entities listed in section 254(h)(7)(B) include non-profit entities that function as one of the listed entities on a part-time basis.[10] Pursuant to this modification, non-profit entities that provide ineligible services, even on a primary basis, would be able to receive prorated support commensurate with their provision of eligible rural health care services.[11] Our goal in implementing this proposal is two-fold – to encourage the development of public/private partnerships and other creative solutions to meet the needs of rural communities, and to increase participation in the rural health care support mechanism. Further, because entities that engage in both eligible and ineligible activities or that collocate with an entity that provides ineligible services will now be eligible for prorated support, we also adopt rules requiring such providers to allocate their discounts to prevent discounts from flowing to ineligible activities or providers of services.[12]

4. We also provide funding for Internet access for rural health care providers.[13] We conclude that support equal to twenty-five percent of the monthly cost for any form of Internet access reasonably related to the health care needs of the facility should be provided to rural health care providers.[14] We believe that the Internet can serve as an invaluable resource, by providing on-line courses in health education, medical research, follow-up care, regulatory information such as compliance with Health Insurance Portability and Accountability Act of 1996, video conferencing, web-based electronic benefit claim systems including on-line billing, and other crucial business functions.[15] The incredible potential of the Internet to access such a breadth of medical information may also help reduce isolation in rural communities. Furthermore, health care information shared over the Internet may enable rural health care providers to diagnose, treat, and contain possible outbreaks of disease or respond to health emergencies. Thus, in light of the development of medical applications for the Internet since 1997, we conclude that encouraging access to this information service will improve the level of care available in rural areas.[16]

5. We also alter our current policy to allow rural health care providers to compare the urban and rural rates for *functionally* similar services as viewed from the perspective of the end

[9] *See supra* para. 14.

[10] *See supra* para. 15.

[11] *Id.*

[12] *See supra* paras. 49-51.

[13] *See supra* para. 22.

[14] *Id.*

[15] *See supra* para. 23.

[16] *Id.*

user.[17] This modification to our rules will better effectuate the mandate of Congress to ensure comparable services for rural areas, as provided in section 254 of the Act, by allowing rural health care providers to benefit from obtaining telecommunications services at rates equivalent to those in urban areas.

6. We also revise section 54.605 of our rules to allow rural health care providers to compare rural rates to urban rates in any city with a population of at least 50,000 in the state, as opposed to the nearest city with a population of 50,000.[18] Allowing comparison to rates in any city in the state acknowledges that rural health care providers may communicate with experts in other cities in the state. Such action also should allow rural health care providers to benefit from the lowest rates for services in the State, thereby providing additional support to develop better telemedicine links.

7. Additionally, we revise the maximum allowable distance (MAD) to equal the distance between the rural health care provider and the farthest point on the jurisdictional boundary of the largest city in that State.[19] Accordingly, for distance-based charges, we modify our rules to provide support to rural health care providers to any location (within or outside of the state) that exceeds the SUD and is less than this revised MAD.[20] We believe, in most instances, calculating the MAD as described above will provide more support for distance-based charges than our current rules, without creating additional administrative burdens for the Administrator. In addition, this modification should provide rural health care providers access to high levels of care and greater flexibility in developing appropriate telehealth networks.

8. Lastly, we revise our policy to allow rural health care providers to receive discounts for satellite services even where alternative terrestrial-based services may be available.[21] However, these discounts will be capped at the amount providers would have received if they purchased functionally similar terrestrial-based alternatives.[22] We conclude this approach furthers the principle of competitive neutrality and recognizes the role that satellite services may play in rural areas without unduly increasing the size of the fund.

B. Summary of Significant Issues Raised by Public Comments in Response to the IRFA

9. No petitions for reconsideration or comments were filed directly in response to the IRFA or on issues affecting small businesses.

C. Description and Estimate of the Number of Small Entities To Which Rules Will Apply

10. The RFA directs agencies to provide a description of, and where feasible, an

[17] *See supra* para. 33.

[18] *See supra* para. 37.

[19] *See supra* para. 40.

[20] *Id.*

[21] *See supra* para. 44.

[22] *Id.*

estimate of the number of small entities that may be affected by the proposed rules, if adopted.[23] The RFA generally defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction."[24] In addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act.[25] A "small business concern" is one which: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the Small Business Administration (SBA).[26]

11. A small organization is generally "any not-for-profit enterprise which is independently owned and operated and is not dominant in its field."[27] Nationwide, as of 1992, there were approximately 275,801 small organizations.[28] The term "small governmental jurisdiction" is defined as "governments of cities, counties, towns, townships, villages, school districts, or special districts, with a population of less than fifty thousand."[29] As of 1997, there were approximately 87,453 government jurisdictions in the United States.[30] This number includes 39,044 counties, municipal governments, and townships, of which 27,546 have populations of fewer than 50,000 and 11,498 counties, municipal governments, and townships have populations of 50,000 or more. Thus, we estimate that the number of small government jurisdictions must be 75,955 or fewer. Small entities potentially affected by the proposals herein include small rural health care providers, small local health departments and agencies, and small eligible service providers offering discounted services to rural health care providers, including telecommunications carriers and ISPs.

a. Rural Health Care Providers

12. Section 254(h)(5)(B) of the Act defines the term "health care provider" and sets forth seven categories of health care providers eligible to receive universal service support.[31] Although SBA has not developed a specific size category for small, rural health care providers,

---

[23] 5 U.S.C. § 603(b)(3).

[24] 5 U.S.C. § 601(6).

[25] 5 U.S.C. § 601(3) (incorporating by reference the definition of "small-business concern" in the Small Business Act, 15 U.S.C. § 632). Pursuant to 5 U.S.C. § 601(3), the statutory definition of a small business applies "unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register."

[26] 15 U.S.C. § 632.

[27] 5 U.S.C. § 601(4).

[28] 1992 Economic Census, U.S. Bureau of the Census, Table 6 (special tabulation of data under contract to Office of Advocacy of the U.S. Small Business Administration).

[29] 5 U.S.C. § 601(5).

[30] 1995 Census of Governments, U.S. Census Bureau, United States Department of Commerce, Statistical Abstract of the United States (2000).

[31] *See* 47 U.S.C. § 254(h)(5)(B).

recent data indicate that there are a total of 8,297 health care providers, consisting of: (1) 625 "post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;" (2) 866 "community health centers or health centers providing health care to migrants;" (3) 1633 "local health departments or agencies;" (4) 950 "community mental health centers;" (5) 1951 "not-for-profit hospitals;" and (6) 2,272 "rural health clinics."[32] We have no additional data specifying the numbers of these health care providers that are small entities. In addition, non-profit entities that act as "health care providers" on a part-time basis will now be eligible to receive prorated support. However, we have no data specifying the number of potential new applicants. Consequently, using the date we do have, we estimate that there are 8,297 or fewer small health care providers potentially affected by the actions proposed in this Notice.

13. As noted earlier, non-profit businesses and small governmental units are considered "small entities" within the RFA. In addition, we note that census categories and associated generic SBA small business size categories provide the following descriptions of small entities.[33] The broad category of Ambulatory Health Care Services consists of further categories and the following SBA small business size standards.[34] The categories of providers with annual receipts of $6 million or less consists of: Offices of Dentists; Offices of Chiropractors; Offices of Optometrists; Offices of Mental Health Practitioners (except Physicians); Offices of Physical, Occupational and Speech Therapists and Audiologists; Offices of Podiatrists; Offices of All Other Miscellaneous Health Practitioners; and Ambulance Services. The category of Ambulatory Health Care Services providers with $8.5 million or less in annual receipts consists of: Offices of Physicians; Family Planning Centers; Outpatient Mental Health and Substance Abuse Centers; Health Maintenance Organization Medical Centers; Freestanding Ambulatory Surgical and Emergency Centers; All Other Outpatient Care Centers, Blood and Organ Banks; and All Other Miscellaneous Ambulatory Health Care Services. The category of Ambulatory Health Care Services providers with $11.5 million or less in annual receipts consists of: Medical Laboratories; Diagnostic Imaging Centers; and Home Health Care Services. The category of Ambulatory Health Care Services providers with $29 million or less in annual receipts consists of Kidney Dialysis Centers. For all of these Ambulatory Health Care Service Providers, census data indicate that there is a combined total of 345,476 firms that operated in 1997.[35] Of these, 339,911 had receipts for that year of less

[32] In the *1997 Universal Service Order,* we estimated that there were (1) 625 "post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools," including 403 rural community colleges, 124 medical schools with rural programs, [FN426] and 98 rural teaching hospitals; (2) 1,200 "community health centers or health centers providing health care to migrants"; (3) 3,093 "local health departments or agencies" including 1,271 local health departments and 1,822 local boards of health; (4) 2,000 "community mental health centers"; (5) 2,049 "not-for-profit hospitals"; and (6) 3,329 "rural health clinics." The total of these numbers was 12,296. *1997 Universal Service Order,* 12 FCC Rcd at 9241-42, para. 924. More recent data, however, indicates that some of these 1997 numbers may have been overstated.

[33] North American Industry Classification System: United States, 1997 at 629-53.

[34] 13 C.F.R. § 121.201; NAICS Codes 621111, 62112, 621210, 621310, 621320, 621330, 621340621391, 621399, 621410, 621420, 621491, 621492, 621493, 621498, 621511, 621512, 621610, 621910, 621991, 621999.

[35] 1997 Economic Census, Establishment of Firm Size, U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration, Document EC97S62S-SZ (*1997 Health Care Data*).

than $5 million.[36] In addition, an additional 3414 firms had annual receipts of $5 million to $9.99 million; and additional 1475 firms had receipts of $10 million to $24.99 million; and an additional 401 had receipts of $25 million to $49.99 million.[37] We therefore estimate that virtually all Ambulatory Health Care Services providers are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

14. The broad category of Hospitals consists of the following categories and the following small business providers with annual receipts of $29 million or less: General Medical and Surgical Hospitals, Psychiatric and Substance Abuse Hospitals; and Specialty Hospitals.[38] For all of these health care providers, census data indicate that there is a combined total of 330 firms that operated in 1997, of which 237 or fewer had revenues of less than $25 million.[39] An additional 45 firms had annual receipts of $25 million to $49.99 million.[40] We therefore estimate that most Hospitals are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

15. The broad category of Nursing and Residential Care Facilities consists of the following categories and the following small business size standards.[41] The category of Nursing and Residential Care Facilities with annual receipts of $6 million or less consists of: Residential Mental Health and Substance Abuse Facilities; Homes for the Elderly; and Other Residential Care Facilities. The category of Nursing and Residential Care Facilities with annual receipts of $8.5 million or less consists of Residential Mental Retardation Facilities. The category of Nursing and Residential Care Facilities with annual receipts of less than $11.5 million consists of Nursing Care Facilities and Continuing Care Retirement Communities. For all of these health care providers, census data indicates that there are a combined total of 18,011 firms that operated in 1997.[42] Of these, 16,165 or fewer firms had annual receipts of below $5 million.[43] In addition, 1205 firms had annual receipts of $5 million to $9.99 million, and 450 firms had receipts of $10 million to $24.99 million.[44] We therefore estimate that a great majority of Nursing and Residential Care Facilities are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

---

[36] *Id.*

[37] *Id.*

[38] 13 C.F.R. § 121.201; NAICS Codes 622110, 622210, 622310.

[39] *1997 Health Care Data.*

[40] *Id.*

[41] 13 C.F.R. § 121.201; NAICS Codes 623110, 623210, 623220, 623311, 623312, 623990.

[42] *1997 Health Care Data.*

[43] *Id.*

[44] *Id.*

16. The broad category of Social Assistance consists of the category of Emergency and Other Relief Services and small business size standard of annual receipts of $6 million or less.[45] For all of these health care providers, census data indicates that there are a combined total of 37,778 firms that operated in 1997.[46] Of these, 37,649 or fewer firms had annual receipts of below $5 million. An additional 73 firms had annual receipts of $5 million to $9.99 million.[47] We therefore estimate that virtually all Social Assistance providers are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

b. Providers of Telecommunications and Other Services

17. We have included small incumbent local exchange carriers in this present RFA analysis. As noted above, a "small business" under the RFA is one that, *inter alia*, meets the pertinent small business size standard (*e.g.*, a telephone communications business having 1,500 or fewer employees), and "is not dominant in its field of operation."[48] The SBA's Office of Advocacy contends that, for RFA purposes, small incumbent local exchange carriers are not dominant in their field of operation because any such dominance is not "national" in scope.[49] We have therefore included small incumbent local exchange carriers in this RFA analysis, although we emphasize that this RFA action has no effect on Commission analyses and determinations in other, non-RFA contexts.

18. *Total Number of Telephone Companies Affected.* The United States Bureau of the Census (the "Census Bureau") reports that, at the end of 1997, there were 6,239 firms engaged in providing telephone services, as defined therein.[50] This number contains a variety of different categories of carriers, including local exchange carriers, interexchange carriers, competitive access providers, cellular carriers, mobile service carriers, operator service providers, pay telephone operators, PCS providers, covered SMR providers, and resellers. It seems certain that some of those 6,239 telephone service firms may not qualify as small entities because they are not "independently owned and operated."[51] For example, a PCS provider that is affiliated with an interexchange carrier having more than 1,500 employees would not meet the definition of a small business. It seems reasonable to conclude, therefore, that 6,239 or fewer telephone

[45] 13 C.F.R. § 121.201; NAICS Code 624230.

[46] *1997 Health Care Data.*

[47] *Id.*

[48] 15 U.S.C. § 632.

[49] Letter from Jere W. Glover, Chief Counsel for Advocacy, SBA, to William E. Kennard, Chairman, FCC (May 27, 1999). The Small Business Act contains a definition of "small-business concern," which the RFA incorporates into its own definition of "small business." *See* 15 U.S.C. § 632(a) (Small Business Act); 5 U.S.C. § 601(3) (RFA). SBA regulations interpret "small business concern" to take into account the concept of dominance on a national basis. 13 C.F.R. § 121.102(b).

[50] 1997 Economic Census, Establishment and Firm Size, U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration, Document EC97S51S-SZ (*1997 Economic Census*), at 67.

[51] 15 U.S.C. § 632(a)(1).

service firms are small entity telephone service firms that may be affected by the decisions and rules adopted in this *Report and Order.*

19. *Local Exchange Carriers, Interexchange Carriers, Competitive Access Providers, Operator Service Providers, Payphone Providers, and Resellers.* Neither the Commission nor SBA has developed a definition particular to small local exchange carriers (LECs), interexchange carriers (IXCs), competitive access providers (CAPs), operator service providers (OSPs), payphone providers or resellers. The closest applicable definition for these carrier-types under SBA rules is for telephone communications companies other than radiotelephone (wireless) companies.[52] The most reliable source of information regarding the number of these carriers nationwide of which we are aware appears to be the data that we collect annually on the Form 499-A. According to our most recent data, there are 1,335 incumbent LECs, 349 CAPs, 204 IXCs, 21 OSPs, 758 payphone providers and 454 resellers.[53] Although it seems certain that some of these carriers are not independently owned and operated, or have more than 1,500 employees, we are unable at this time to estimate with greater precision the number of these carriers that would qualify as small business concerns under SBA's definition. Consequently, we estimate that there are fewer than 1,335 incumbent LECs, 349 CAPs, 204 IXCs, 21 OSPs, 758 payphone providers, and 541 resellers that may be affected by the decisions and rules adopted in this *Report and Order*.

20. *Internet Service Providers.* The SBA has developed a small business size standard for "On-Line Information Services," NAICS code 514191.[54] This category comprises establishments "primarily engaged in providing direct access through telecommunications networks to computer-held information compiled or published by others."[55] Under this small business size standard, a small business is one having annual receipts of $18 million or less.[56] Based on firm size data provided by the Bureau of the Census, 3,123 firms are small under SBA's $18 million size standard for this category code.[57] Although some of these Internet Service Providers (ISPs) might not be independently owned and operated, we are unable at this time to estimate with greater precision the number of ISPs that would qualify as small business concerns under SBA's small business size standard. Consequently, we estimate that there are 3,123 or fewer small entity ISPs that may be affected.

21. *Satellite Service Carriers.* The SBA has developed a definition for small businesses

---

[52] 13 C.F.R. § 121.210, North American Industry Classification System (NAICS) Codes 513310, 513330, 513340.

[53] *See* FCC, Common Carrier Bureau, Industry Analysis Division, *Trends in Telephone Service*, Table 5.3 (August 2001) (*Telephone Trends Report*). The total for resellers includes both toll resellers and local resellers. The category for CAPs also includes competitive local exchange carriers (LECs).

[54] *See generally* North American Industry Classification System – United States (1997), NAICS code 514191.

[55] *See generally* North American Industry Classification System – United States (1997), NAICS code 514191.

[56] 13 CFR § 121.201, NAICS code 514191.

[57] Office of Advocacy, U.S. Small Business Administration, Firm Size Data by Industry and Location.

within the category of Satellite Telecommunications. According to SBA regulations, a small business under the category of Satellite communications is one having annual receipts of $12.5 million or less.[58] According to SBA's most recent data, there are a total of 371 firms with annual receipts of $9,999,999 or less, and an additional 69 firms with annual receipts of $10,000,000 or more.[59] Thus, the number of Satellite Telecommunications firms that are small under the SBA's $12 million size standard is between 371 and 440. Further, some of these Satellite Service Carriers might not be independently owned and operated. Consequently, we estimate that there are fewer than 440 small entity ISPs that may be affected by the decisions and rules of the present action.

22. *Wireless Service Providers.* The SBA has developed a definition for small businesses within the two separate categories of Cellular and Other Wireless Telecommunications or Paging. Under that SBA definition, such a business is small if it has 1,500 or fewer employees.[60] According to the Commission's most recent Telephone Trends Report data, 1,495 companies reported that they were engaged in the provision of wireless service.[61] Of these 1,495 companies, 989 reported that they have 1,500 or fewer employees and 506 reported that, alone or in combination with affiliates, they have more than 1,500 employees. We do not have data specifying the number of these carriers that are not independently owned and operated, and thus are unable at this time to estimate with greater precision the number of wireless service providers that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that there are 989 or fewer small wireless service providers that may be affected by the rules.

23. *Cable and Other Subscription Programming or Other Program Distribution and Related Entities.* The SBA has developed small business size standards which include all such companies generating $12.5 million or less in revenue annually. These standards cover two categories of Cable Services: Cable and Other Subscription Programming; and Cable and Other Program Distribution.

24. *Cable and Other Subscription Programming.*[62] This industry comprises establishments primarily engaged in operating studios and facilities for the broadcasting of programs on a subscription or fee basis. These establishments produce programming in their own facilities or acquire programming from external sources. The programming material is usually delivered to a third party, such as cable systems or direct-to-home satellite systems, for transmission to viewers. According to Census Bureau data for 1997, there were a total of 234 firms in this category, total, that had operated for the entire year. Of this total, 188 firms had

[58] 13 C.F.R. § 121.201; NAICS Code 513340.

[59] *1997 Economic Census* at 16.

[60] 13 C.F.R. § 121.210; NAICS Code 513322.

[61] *Telephone Trends Report*, Table 5.3.

[62] 13 CFR § 121.201, North American Industry Classification System (NAICS) code 513210 (changed to 515210 in October 2002).

annual receipts of under $10 million.[63] Consequently, the Commission estimates that the majority of providers in this service category are small businesses that may be affected by the rules and policies adopted herein.

25. *Cable and Other Program Distribution.*[64] This category includes cable systems operators, closed circuit television services, direct broadcast satellite services, multipoint distribution systems, satellite master antenna systems, and subscription television services. According to Census Bureau data for 1997, there were a total of 1,311 firms in this category, total, that had operated for the entire year.[65] Of this total, 1,180 firms had annual receipts of under $10 million and an additional 52 firms had receipts of $10 million or more but less than $25 million. Consequently, the Commission estimates that the majority of providers in this service category are small businesses that may be affected by the rules and policies adopted herein.

D. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

26. The *Report and Order* adopts several modifications to the Commission's rules to improve the effectiveness of the rural health care universal service support mechanism and increase utilization of this mechanism by rural health care providers. As articulated above, in the *Report and Order*, we clarify the scope of entities eligible to receive discounts.[66] Specifically, because entities that engage in eligible and ineligible activities or that collocate with an entity that provides ineligible services will now be eligible for prorated support, we adopt rules requiring such providers to allocate their discounts to prevent discounts from flowing to ineligible activities or providers of services.[67] Health care providers are required to maintain documentation explaining their allocation methods for five years and present that information to USAC upon request.[68] The method of cost allocation chosen by an applicant should be based on objective criteria and reasonably reflect the eligible usage of the facilities. Additionally, health care providers must maintain for their purchases of supported services procurement records for at least five years sufficient to document their compliance with all Commission requirements.[69]

E. Steps Taken to Minimize Significant Economic Impact on Small Entities, and

[63] U.S. Census Bureau, 1997 Economic Census, Subject Series: Information, "Establishment and Firm Size (Including Legal Form of Organization)", Table 4, NAICS code 513210 (issued October 2000).

[64] 13 CFR § 121.201, North American Industry Classification System (NAICS) code 513220 (changed to 517510 in October 2002).

[65] U.S. Census Bureau, 1997 Economic Census, Subject Series: Information, "Establishment and Firm Size (Including Legal Form of Organization)", Table 4, NAICS code 513220 (issued October 2000).

[66] *See supra* paras. 13-17.

[67] 47 C.F.R. § 54.601(d) as adopted herein.

[68] *See* 47 C.F.R. § 54.619(a)(1) as adopted herein.

[69] 47 C.F.R. § 54.619(a)(1) as adopted herein.

Significant Alternatives Considered

27. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach impacting small business, which may include the following four alternatives (among others): (1) the establishment of differing compliance and reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or part thereof, for small entities.[70]

28. In this *Report and Order*, we amend our rules to improve the program, increase participation by rural health care providers, and ensure that the benefits of the program continue to be distributed in a fair and equitable manner. Specifically, we expand the scope of entities eligible to receive discounts, provide support for Internet access, and modify the way in which we calculate discounts to offer rural health care providers more flexibility. The actions taken in the *Report and Order* help improve the quality of health care services available in rural America, and better enable rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease. Thus, rural health care providers stand to benefit directly from the modifications to our rules and policies.

F. Report to Congress

29. The Commission will send a copy of the *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, including this FRFA, in a report to be sent to Congress pursuant to the Congressional Review Act.[71] In addition, the Commission will send a copy of the *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, including this FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of the *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking* and FRFA (or summaries thereof) will also be published in the Federal Register.[72]

[70] *See* 5 U.S.C. §§ 603(c)(1)-(4).

[71] *See* 5 U.S.C. § 801(a)(1)(A).

[72] *See* 5 U.S.C. § 604(b).

APPENDIX D

INITIAL REGULATORY FLEXIBILITY ANALYSIS

(*FURTHER NOTICE OF PROPOSED RULEMAKING*)

1. As required by the Regulatory Flexibility Act of 1980, as amended (RFA),[1] the Commission has prepared the present Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and rules proposed in this *Further Notice*. Written public comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments on *the Further Notice* provided below in Section VI(C) above. The Commission will send a copy of the *Further Notice*, including this IRFA, to the Chief Counsel for Advocacy of the Small Business Administration.[2] In addition, the *Further Notice* and IRFA (or summaries thereof) will be published in the Federal Register.[3]

A. Need for, and Objectives of, the Proposed Rules

2. The Commission is required by section 254 of the Act to promulgate rules to implement the universal service provisions of section 254.[4] On May 8, 1997, the Commission adopted rules that reformed its system of universal service support mechanisms so that universal service is preserved and advanced as markets move toward competition.[5] Among other things, the Commission adopted a mechanism to provide discounted telecommunications services to public or non-profit health care providers that serve persons in rural areas. Over the last few years, important changes in the rural health community prompt us to review the rural health care universal service support mechanism.[6]

3. In this *Further Notice*, we seek comment on whether and how to modify the definition of rural area as utilized in the rural health care support mechanism.[7] We also seek comment on whether additional modifications to our rules are appropriate to facilitate the provision of support to mobile rural health clinics for satellite services.[8] Lastly, we seek

[1] *See* 5 U.S.C. § 603. The IRFA, see 5 U.S.C. §§ 601-12, has been amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA) Pub. L. No. 104-121, Title II, 110 Stat 857 (1996).

[2] *See* 5 U.S.C. § 603(a).

[3] *See id.*

[4] 47 U.S.C. § 254.

[5] *1997 Universal Service Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

[6] *See supra* paras. 8-10.

[7] *See supra* paras. 63-64.

[8] *See supra* paras. 65-68.

comments on ways to streamline further the application process and expand outreach efforts.[9]

B. Legal Basis

4. This *Further Notice* is adopted pursuant to sections 1, 4(i), (4j), 201-205, 251, 252, and 303 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151, 154(i), (j), 201-205, 251, 252, and 303.

C. Description and Estimate of the Number of Small Entities To Which Rules Will Apply

5. The RFA directs agencies to provide a description of, and, where feasible, an estimate of the number of small entities that may be affected by the rules adopted herein.[10] The RFA generally defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction."[11] In addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act, unless the Commission has developed one or more definitions that are appropriate to its activities.[12] Under the Small Business Act, a "small business concern" is one that: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) meets any additional criteria established by the Small Business Administration (SBA).[13]

6. We have described in detail, *supra*, in the FRFA, the categories of entities that may be directly affected by any rules or proposals adopted in our efforts to reform the universal service rural health care support mechanism.[14] For this IRFA, we hereby incorporate those entity descriptions by reference.

D. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

7. The *Further Notice* seeks comment on potential changes to the definition of "rural area" for the rural health care support mechanism. This potential change will not impact reporting or recordkeeping requirements, however, it could impact the overall pool of eligible applicants. The *Further Notice* also seeks comment on whether additional support should be provided to mobile rural health clinics that utilize satellite services. If changes are adopted, mobile rural health clinics, including small rural health clinics, could potentially be required to

[9] *See supra* para. 69.

[10] 5 U.S.C. § 604(a)(3).

[11] 5 U.S.C. § 601(6).

[12] 5 U.S.C. § 601(3) (incorporating by reference the definition of "small business concern" in 5 U.S.C. § 632). Pursuant to 5 U.S.C. § 601(3), the statutory definition of a small business applies "unless an agency after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition in the Federal Register."

[13] 15 U.S.C. § 632.

[14] *See supra* Appendix C, paras. 10-24.

submit additional information regarding their mobile services, if they choose to seek discounts. Lastly, the *Further Notice* seeks comment on ways to streamline further the application process. If the application process is streamlined further, this would eliminate some of the paperwork associated with the application process.

E. Steps Taken to Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered

8. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach impacting small business, which may include the following four alternatives (among others): (1) the establishment of differing compliance and reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or part thereof, for small entities.[15]

9. In this *Further Notice*, we seek comment on a new definition of rural area. If a new definition is adopted, this could change the size of the overall pool of eligible applicants for universal service support for rural health care providers. We also seek comment on whether to provide additional support to mobile rural health clinics that utilize satellite services. In seeking to minimize the burdens imposed on small entities where doing so does not compromise the goals of the universal service mechanism, we invite comment on definitions and proposals for additional support for mobile rural health clinics that might be made less burdensome for small entities. In addition, we seek comment on ways to streamline further the application process and expand outreach efforts. If the application process is streamlined further, this could ease the burden on small entities associated with the application process. Additionally, outreach efforts would better inform such businesses about the benefits of the rural health care program and potentially increase small business participation in the program.

F. Federal Rules that May Duplicate, Overlap, or Conflict with the Proposed Rules

10. None.

[15] *See* 5 U.S.C. §§ 603(c)(1)-(4).

SEPARATE STATEMENT OF CHAIRMAN MICHAEL K. POWELL

Re: Rural Health Care Support Mechanism, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking

Telemedicine creates medical expertise on demand for people living in rural America. The telemedicine support measures we adopt today have the potential to bring millions of Americans from rural and remote parts of the country closer than ever to top-quality doctors and medical specialists. Geographic isolation should no longer be a barrier to timely, quality medical care.

Telemedicine networks are also integral to our homeland security efforts. In times of national crisis, telemedicine networks can bring much-needed healthcare information to first responders. For example, telemedicine capabilities serve as a link between medical professionals and homeland security teams to ensure that experts are available in the event of a biological or chemical attack.

Although the rural health care program has a $400 million annual maximum, demand for Funding Years 2000 and 2001 averaged approximately $14 million a year. Today, we adopt rule changes to encourage the development of public/private partnerships and other creative solutions to meet the needs of rural communities and increase participation in the rural health care program. Today's Order clarifies that dedicated emergency departments in for-profit rural hospitals are "public" health care providers eligible for support because these rural hospitals are required by other federal laws to examine and stabilize all patients who walk in the door. The rule changes we adopt today represent important reforms of our eligibility criteria and should ensure scope of services eligible for support under our rural health care program.

Most residents in rural or remote areas of the country do not have the luxury of even one major medical facility near their homes, much less access to the world-renowned team of doctors, clinicians and researchers that major educational institutions and research hospitals can assemble. Innovations in computing and telecommunications technology, however, allow doctors to perform many medical procedures even though hundreds or even thousands of miles separate doctor and patient. Recently, I witnessed the transformative potential of telemedicine when I visited the University of Virginia's Office of Telemedicine. At the University of Virginia, I saw firsthand not only the types of technologies that doctors can use to improve health care, but also the telecommunications services – and service providers – that are making telemedicine a reality in rural areas of America and across the globe. The changes to our rural health care program that we adopt today probably may not bring back housecalls, but they will help promote the admirable goal of helping to extend the expertise of some of the nation's most advanced medical professionals into some of the nation's most rural and remote areas.

I look forward to working with my colleagues to unlock the potential of this program and to expeditiously addressing the issues presented in the Further Notice.

SEPARATE STATEMENT OF COMMISSIONER KATHLEEN Q. ABERNATHY

Re: Rural Health Care Support Mechanism, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking

I am extremely pleased to support this Order and its significant improvements to the rural health care support mechanism. While the universal service programs overall have successfully delivered benefits to consumers living in high-cost areas, to patrons of schools and libraries, and to persons of limited means, there is no question that the rural health care mechanism has been underutilized. I am confident that today's action will more faithfully deliver on Congress's promise to lower telecommunications costs for health care providers serving rural communities.

In turn, our action should make telemedicine available for many consumers for whom visits to specialists otherwise would cause great hardships. We often talk about the benefits of broadband services, but telemedicine may be the most important application of them all. Telemedicine has the potential to make it irrelevant whether a patient lives in a downtown urban area or on a mountaintop. I have seen demonstrations of how telemedicine connects patients in remote areas of Alaska to hospitals and clinics hundreds of miles away, often preventing the ordeal (and immense cost) of air transport. I was also privileged to have the opportunity last week to visit the University of Virginia's exemplary telemedicine program, which serves consumers throughout the Appalachian region of the state. It was truly heartwarming to hear testimonials from patients whose lives have been improved by the availability of high-speed telecommunications links throughout rural Virginia. And it was awe-inspiring to listen to a patient's heartbeat or view a cardiac ultrasound in perfect fidelity and clarity from hundreds of miles away. Dr. Karen Rheuban and her colleagues have done an amazing job at UVA, and I hope other states and institutions follow their example.

I also hope that we will find ways in the further rulemaking to fund mobile clinics, such as the satellite-enabled mammography van that Healthcare Anywhere proposes to use to serve women on tribal lands in North and South Dakota. Such innovative ideas not only would bring critical health care services to underserved communities, but also might lower health care costs by making preventive care more widespread.

Finally, while I fully support taking steps that are likely to drive up the demand for universal service funding, I am confident that our rules will continue to ensure that funding needs are met without waste, fraud, or abuse. For example, although we have expanded the program to provide discounts on Internet access for the first time, we have set the initial discount rate for Internet access at a modest 25 percent to prevent excessive fund growth and to ensure that providers have adequate incentives to avoid overpayment. In time, we may decide that additional funding is warranted, but we must balance the tremendous benefits of telemedicine against the significant burdens that are being placed on consumers to fund our various universal service support mechanisms. At this point, the balance clearly tilts in favor of expanding the program, because it has barely begun to fulfill Congress's mandate to establish an effective rural health care support mechanism.

SEPARATE STATEMENT OF COMMISSIONER MICHAEL J. COPPS

Re: Rural Health Care Support Mechanism, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking

I am pleased—very pleased—to see this rural health care item on our agenda today. This is a program that we need to put to work. We need to put it to work because rural America lags the rest of the country in access to premium health care, and we need to do it now more than ever because of the heightened threats of bio-terrorism and health catastrophe that follow in the wake of 9/11. Rural America wasn't where it should have been in access to good health services before 9/11, and if terror visited there now, all the reports tell us, rural America is less-equipped to deal with it than we are in the metropolitan areas, and goodness knows we need a lot of improvements here, too.

For those who are interested in seeing how rural health care providers can make use of telecommunications infrastructure to provide needed services, it's there to see. In growing numbers of places, you can see telemedicine and telehealth improving the quality of life in rural communities by providing patients in remote areas with access to services that would otherwise have been unavailable. We are seeing patient diagnostic services, patient follow-up care, educational offerings for rural health care professionals, and the dissemination of all sorts of critical health–related information.

Last week, I had the opportunity to learn about this first-hand when I spent some quality time in the south central Wisconsin town of Beaver Dam, at the Beaver Dam Community Hospital. I had the opportunity there to have a long conversation with the people who run this rural facility and the people responsible for the telecommunications technologies used to provide patient care.

Here at the Commission we now understand that our Rural Health Care Program has not lived up to its potential. We set aside as much as $400 million annually, but in the first five years of the program, just over $30 million was disbursed to rural facilities. This is not on the scale of what I suspect the Commission had in mind when the program was first set up, and it is certainly not on the scale of what Congress had in mind when it directed the Commission to ensure that health care providers serving rural communities have access to services on par with those available in urban areas. And, as I said a minute ago, it falls even farther short of what it should be in light of 9/11.

In response, we change our rules today. In particular, we expand our interpretation of eligible health care providers, provide flat support for Internet access and revise our standard for urban area rate comparisons. I support these changes because I believe they will improve the Rural Health Care Program in a manner that is consistent with our statutory mandate.

But other problems—serious problems—remain and they keep this program from being utilized the way it should be utilized. My conversations in Beaver Dam, and my earlier conversations in the remote town of Levelock, Alaska, convince me that basic lack of outreach and a cumbersome application process may be the real culprits here.

The Rural Health Care Program is only as strong as the community that knows about it. And you know what? A lot of communities don't know about this program. So, for openers, we need to work much more closely with the American Hospital Association, state health care organizations, rural government associations and telecommunications carriers serving rural communities to get the word out. Like so many of our universal service programs designed for end-user beneficiaries—without outreach they risk irrelevance, perhaps even extinction.

Then there is the application process. It needs a major overhaul. At Beaver Dam Community Hospital, they spent six months to secure what wound up being only a single month of funding. Figuring out the appropriate discount rate, securing necessary information from telecommunications carriers and completing the mountain of related forms is a time consuming and arduous task. The application calls on health care professionals to master the complexities of such things as total billed miles and the intricacies of all sorts of convoluted tariff rates. These rural hospitals have limited staff, they have urgent priorities, and in a matter like this, where months of work translate into a couple thousand dollars of one-month support, they question if the paper chase is at all worth it. From what I saw, I don't blame them. And I fear Beaver Dam's experience is not unusual. I know that USAC has recently made some improvements, including a new database of urban rates and enhanced electronic filing capabilities and also making the second year application easier, and I congratulate them for that. But we can, we should, and we must do more. We are justifiably concerned with deterring waste and abuse, but we should recognize that the complexity of the process here is deterring worthy applicants—and that is really waste and abuse.

I commend the Chairman and the Wireline Competition Bureau for developing this item today, and I am encouraged that the Chairman and Commissioner Abernathy made a trip last week to visit the University of Virginia Office of Telemedicine. Raising the profile of this program helps. Today's Order helps. And tackling some of these other problems would help. This program involves national security and our national well-being. We can all be zealous advocates for this cause. I look forward to working with my colleagues, the Bureau, rural health care providers and the industry to make this program what it deserves to be.

SEPARATE STATEMENT OF COMMISSIONER JONATHAN S. ADELSTEIN

Re: Rural Health Care Support Mechanism, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking

Today we modify our rules to improve the effectiveness of the rural health care support mechanism. I believe that the modifications that we make will improve the program, increase participation of rural health care providers, and ensure that benefits of the program continue to be distributed in a fair and equitable manner. This program has not yet met the Commission's projections, and has not lived up to Congress' expectations. These changes will help the program fulfill its enormous potential to improve the quality of health care in rural America.

Today's decision is one of those that really makes our jobs as public servants incredibly rewarding. There are only winners in today's decision. And we are all winners as a result of today's decision. A chain is only as strong as its weakest link, and today we further fortify the links in our communications network.

As a result of today's decision, more entities will be eligible for funding. It is critically important that we now permit funding of dedicated emergency facilities in for-profit hospitals as "rural health care clinics". These facilities are often the first line of defense and the portal for the patients' entry into the health care system. This change is particularly important in light of our national security concerns and the need to address any national emergency situation that may present itself. For example, if there is a chemical or biological attack and a patient presents himself to the dedicated care facility, access to rural health care funding may help ensure a quicker, more comprehensive determination of the crisis at hand, potentially saving many lives.

It is critical that we will allow for funding of "part-time" rural health care facilities. This is the reversal of a prior rule that rural health care providers associated with non-profit nursing homes, hospices and long term care facilities are 100% ineligible for funding. It will enhance the availability of health care in rural areas that don't have any other option or entity to serve as a health care facility.

Today we also approve funding for Internet access to rural health care providers. We are directing USAC to provide to rural health care providers twenty-five percent of the monthly cost for any form of Internet access reasonably related to the health care needs of the facility. Internet access has changed the world and our interaction with it. The Internet brings the world to us. In remote rural areas, access to the wealth of information and instruction that the Internet provides can mean the difference between life and death. I believe that a twenty-five percent discount is appropriate at this time, but I am willing to consider a higher discount based on the usage we see.

Under our old rules, we would allow rural health care providers to compare their rural rates to urban rates in the nearest city with a population of 50,000. Now we allow the health care providers to compare their rates to any city in their state with a population of greater than 50,000. We have learned through experience that the rural health care providers don't necessarily always choose to connect to a point in the nearest largest city, but may very well choose to connect elsewhere where their needs are better met. This improvement that we make today will allow for rural health care providers to enjoy lower rates and provide access to the services that are most

useful for their facilities.

I strongly support the revision of our policy to allow rural health care providers to receive discounts for satellite services even where alternative terrestrial based services may be available. Different technologies may be better suited to different health care providers and the services that they wish to offer. We should not limit a health care provider's ability to make that assessment and subsequent choice. I do believe, however, that in order to appropriately oversee this fund, capping the discount at the amount providers would have received if they had purchased functionally similar terrestrial-based alternatives is an important addition to prevent waste, fraud and abuse.

I am also pleased that we are continuing to look at the myriad of ways to improve this program by asking questions about the appropriate definition of a rural area. In addition, we are requesting comment on the provision of support to mobile rural health care clinics for satellite services. These questions are imperative to continuing to improve this program that has already done so much good, but can clearly do more. I eagerly await the ideas that health care and service providers will offer in response to our request for more information.

Finally, I'd like to thank USAC for the fine job it has done to help promote this program and all the other universal service programs it administers. I know that USAC works very closely with our staff and serves as a resource that helps us make better, more knowledgeable decisions. In particular I'd like to thank Cheryl Parrino for her leadership and wish her well as she moves on to her next challenge. She will be missed.

I approve this item and look forward to future advances in the program that result from our actions today.